

106TH CONGRESS
2D SESSION

S. 2758

To amend title XVIII of the Social Security Act to provide coverage of outpatient prescription drugs under the medicare program.

IN THE SENATE OF THE UNITED STATES

JUNE 20, 2000

Mr. GRAHAM (for himself, Mr. BRYAN, Mr. ROBB, Mr. CONRAD, Mr. L. CHAFEE, Mr. BAUCUS, Mr. ROCKEFELLER, and Mrs. LINCOLN) introduced the following bill; which was read twice and referred to the Committee on Finance

A BILL

To amend title XVIII of the Social Security Act to provide coverage of outpatient prescription drugs under the medicare program.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

4 (a) SHORT TITLE.—This Act may be cited as the
5 “Medicare Outpatient Drug Act of 2000”.

6 (b) TABLE OF CONTENTS.—The table of contents of
7 this Act is as follows:

Sec. 1. Short title; table of contents.

Sec. 2. Medicare outpatient prescription drug benefit program.

“PART D—OUTPATIENT PRESCRIPTION DRUG BENEFIT PROGRAM

“Sec. 1860. Definitions.

“SUBPART 1—ESTABLISHMENT OF OUTPATIENT PRESCRIPTION DRUG
BENEFIT PROGRAM

“Sec. 1860A. Establishment of outpatient prescription drug benefit program.

“Sec. 1860B. Enrollment.

“Sec. 1860C. Providing information to beneficiaries.

“Sec. 1860D. Premiums.

“Sec. 1860E. Cost-sharing.

“Sec. 1860F. Selection of entities to provide outpatient drug benefit.

“Sec. 1860G. Conditions for awarding contract.

“Sec. 1860H. Payments.

“Sec. 1860I. Employer incentive program for employment-based retiree drug coverage.

“Sec. 1860J. Appropriations.

“SUBPART 2—MEDICARE PHARMACY AND THERAPEUTICS (P&T) ADVISORY
COMMITTEE

“Sec. 1860M. Medicare Pharmacy and Therapeutics (P&T) Advisory Committee.”.

Sec. 3. Part D benefits under Medicare+Choice plans.

Sec. 4. Exclusion of part D costs from determination of part B monthly premium.

Sec. 5. Reporting requirements for Secretary of the Treasury regarding income-related part D premium.

Sec. 6. Additional assistance for low-income beneficiaries.

Sec. 7. Medigap revisions.

Sec. 8. HHS studies and report to Congress.

Sec. 9. Appropriations.

1 SEC. 2. MEDICARE OUTPATIENT PRESCRIPTION DRUG BEN-
2 EFIT PROGRAM.

3 (a) ESTABLISHMENT.—Title XVIII of the Social Se-
4 curity Act (42 U.S.C. 1395 et seq.) is amended by redesign-
5 nating part D as part E and by inserting after part C
6 the following new part:

7 “PART D—OUTPATIENT PRESCRIPTION DRUG BENEFIT
8 PROGRAM

9 “DEFINITIONS

10 “SEC. 1860. In this part:

1 “(1) COVERED OUTPATIENT DRUG.—

2 “(A) IN GENERAL.—Except as provided in
3 subparagraph (B), the term ‘covered outpatient
4 drug’ means any of the following products:

5 “(i) A drug which may be dispensed
6 only upon prescription, and—

7 “(I) which is approved for safety
8 and effectiveness as a prescription
9 drug under section 505 of the Federal
10 Food, Drug, and Cosmetic Act;

11 “(II)(aa) which was commercially
12 used or sold in the United States be-
13 fore the date of enactment of the
14 Drug Amendments of 1962 or which
15 is identical, similar, or related (within
16 the meaning of section 310.6(b)(1) of
17 title 21 of the Code of Federal Regu-
18 lations) to such a drug, and (bb)
19 which has not been the subject of a
20 final determination by the Secretary
21 that it is a ‘new drug’ (within the
22 meaning of section 201(p) of the Fed-
23 eral Food, Drug, and Cosmetic Act)
24 or an action brought by the Secretary
25 under section 301, 302(a), or 304(a)

1 of such Act to enforce section 502(f)
2 or 505(a) of such Act; or

3 “(III)(aa) which is described in
4 section 107(c)(3) of the Drug Amend-
5 ments of 1962 and for which the Sec-
6 retary has determined there is a com-
7 pelling justification for its medical
8 need, or is identical, similar, or re-
9 lated (within the meaning of section
10 310.6(b)(1) of title 21 of the Code of
11 Federal Regulations) to such a drug,
12 and (bb) for which the Secretary has
13 not issued a notice of an opportunity
14 for a hearing under section 505(e) of
15 the Federal Food, Drug, and Cos-
16 metic Act on a proposed order of the
17 Secretary to withdraw approval of an
18 application for such drug under such
19 section because the Secretary has de-
20 termined that the drug is less than ef-
21 fective for all conditions of use pre-
22 scribed, recommended, or suggested in
23 its labeling.

24 “(ii) A biological product which—

1 “(I) may only be dispensed upon
2 prescription;

3 “(II) is licensed under section
4 351 of the Public Health Service Act;
5 and

6 “(III) is produced at an estab-
7 lishment licensed under such section
8 to produce such product.

9 “(iii) Insulin approved under appro-
10 priate Federal law, including needles, sy-
11 ringes, and disposable pumps for the ad-
12 ministration of such insulin.

13 “(iv) A prescribed drug or biological
14 product that would meet the requirements
15 of clause (i) or (ii) but that it is available
16 over-the-counter in addition to being avail-
17 able upon prescription.

18 “(B) EXCLUSION.—The term ‘covered out-
19 patient drug’ does not include any product—

20 “(i) except as provided in subpara-
21 graph (A)(iv), which may be distributed to
22 individuals without a prescription;

23 “(ii) that is covered under part A or
24 B (unless coverage of such product is not

1 available because benefits under part A or
 2 B have been exhausted); or

3 “(iii) except for agents used to pro-
 4 mote smoking cessation, for which cov-
 5 erage may be excluded or restricted under
 6 section 1927(d)(2).

7 “(2) ELIGIBLE BENEFICIARY.—The term ‘eligi-
 8 ble beneficiary’ means an individual that is entitled
 9 to benefits under part A or enrolled under part B.

10 “(3) ELIGIBLE ENTITY.—The term ‘eligible en-
 11 tity’ means any entity that the Secretary determines
 12 to be appropriate to provide eligible beneficiaries
 13 with covered outpatient drugs under a contract en-
 14 tered into under this part, including—

15 “(A) a pharmacy benefit management com-
 16 pany;

17 “(B) a retail pharmacy delivery system;

18 “(C) a health plan or insurer;

19 “(D) a State (through mechanisms estab-
 20 lished under a State plan under title XIX);

21 “(E) any other entity approved by the Sec-
 22 retary; or

23 “(F) any combination of the entities de-
 24 scribed in subparagraphs (A) through (E) if the
 25 Secretary determines that such combination—

1 “(i) increases the scope or efficiency
 2 of the provision of benefits under this part;
 3 and

4 “(ii) is not anticompetitive.

5 “SUBPART 1—ESTABLISHMENT OF OUTPATIENT
 6 PRESCRIPTION DRUG BENEFIT PROGRAM

7 “ESTABLISHMENT OF OUTPATIENT PRESCRIPTION DRUG
 8 BENEFIT PROGRAM

9 “SEC. 1860A. (a) PROVISION OF BENEFIT.—Begin-
 10 ning in 2003, the Secretary shall provide for an outpatient
 11 prescription drug benefit program under which an eligible
 12 beneficiary shall be provided covered outpatient drugs.

13 “(b) VOLUNTARY NATURE OF PROGRAM.—Nothing
 14 in this part shall be construed as requiring an eligible ben-
 15 eficiary to enroll in the program established under this
 16 part.

17 “(c) SCOPE OF BENEFITS.—The program established
 18 under this part shall provide for coverage of all therapeutic
 19 classes of covered outpatient drugs.

20 “(d) FINANCING.—The costs of providing benefits
 21 under this part shall be payable from the Federal Supple-
 22 mentary Medical Insurance Trust Fund established under
 23 section 1841.

24 “ENROLLMENT

25 “SEC. 1860B. (a) ENROLLMENT UNDER PART D.—

26 “(1) ESTABLISHMENT OF PROCESS.—

“(A) IN GENERAL.—The Secretary shall establish a process through which an eligible beneficiary (including an eligible beneficiary enrolled in a Medicare+Choice plan offered by a Medicare+Choice organization) may make an election to enroll under this part. Such process shall be similar to the process for enrollment in part B under section 1837.

“(B) REQUIREMENT OF ENROLLMENT.—An eligible beneficiary must enroll under this part in order to be eligible to receive covered outpatient drugs under this title.

“(2) ENROLLMENT PROCEDURES.—

“(A) LATE ENROLLMENT PENALTY.—

“(i) IN GENERAL.—Subject to the succeeding provisions of this subparagraph, in the case of an eligible beneficiary whose coverage period under this part began pursuant to an enrollment after the beneficiary’s initial enrollment period under part B (determined pursuant to section 1837(d)) and not pursuant to the open enrollment period described in subparagraph (B), the Secretary shall establish procedures for increasing the amount of the

1 monthly premium under section 1860D ap-
 2 plicable to such beneficiary—

3 “(I) by an amount that is equal
 4 to 10 percent of such premium for
 5 each full 12-month period (in the
 6 same continuous period of eligibility)
 7 in which the eligible beneficiary could
 8 have been enrolled under this part but
 9 was not so enrolled; or

10 “(II) if determined appropriate
 11 by the Secretary, by an amount that
 12 the Secretary determines is actuarially
 13 sound for each such period.

14 “(ii) PERIODS TAKEN INTO AC-
 15 COUNT.—For purposes of calculating any
 16 12-month period under clause (i), there
 17 shall be taken into account—

18 “(I) the months which elapsed
 19 between the close of the eligible bene-
 20 ficiary’s initial enrollment period and
 21 the close of the enrollment period in
 22 which the beneficiary enrolled; and

23 “(II) in the case of an eligible
 24 beneficiary who reenrolls under this
 25 part, the months which elapsed be-

1 tween the date of termination of a
2 previous coverage period and the close
3 of the enrollment period in which the
4 beneficiary reenrolled.

5 “(iii) PERIODS NOT TAKEN INTO AC-
6 COUNT.—

7 “(I) IN GENERAL.—For purposes
8 of calculating any 12-month period
9 under clause (i), subject to subclause
10 (II), there shall not be taken into ac-
11 count months for which the eligible
12 beneficiary can demonstrate that the
13 beneficiary was covered under a group
14 health plan, including a qualified re-
15 tiree prescription drug plan (as de-
16 fined in section 1860I(e)(3)) for which
17 an incentive payment was paid under
18 section 1860I, that provides coverage
19 of the cost of prescription drugs
20 whose actuarial value (as defined by
21 the Secretary) to the beneficiary
22 equals or exceeds the actuarial value
23 of the benefits provided to an indi-
24 vidual enrolled in the outpatient pre-

1 scription drug benefit program under
2 this part.

3 “(II) APPLICATION.—This clause
4 shall only apply with respect to a cov-
5 erage period the enrollment for which
6 occurs before the end of the 60-day
7 period that begins on the first day of
8 the month which includes the date on
9 which the plan terminates, ceases to
10 provide, or reduces the value of the
11 prescription drug coverage under such
12 plan to below the value of the cov-
13 erage provided under the program
14 under this part.

15 “(iv) PERIODS TREATED SEPA-
16 RATELY.—Any increase in an eligible bene-
17 ficiary’s monthly premium under clause (i)
18 with respect to a particular continuous pe-
19 riod of eligibility shall not be applicable
20 with respect to any other continuous period
21 of eligibility which the beneficiary may
22 have.

23 “(v) CONTINUOUS PERIOD OF ELIGI-
24 BILITY.—

1 “(I) IN GENERAL.—Subject to
 2 subclause (II), for purposes of this
 3 subparagraph, an eligible beneficiary’s
 4 ‘continuous period of eligibility’ is the
 5 period that begins with the first day
 6 on which the beneficiary is eligible to
 7 enroll under section 1836 and ends
 8 with the beneficiary’s death.

9 “(II) SEPARATE PERIOD.—Any
 10 period during all of which an eligible
 11 beneficiary satisfied paragraph (1) of
 12 section 1836 and which terminated in
 13 or before the month preceding the
 14 month in which the beneficiary at-
 15 tained age 65 shall be a separate ‘con-
 16 tinuous period of eligibility’ with re-
 17 spect to the beneficiary (and each
 18 such period which terminates shall be
 19 deemed not to have existed for pur-
 20 poses of subsequently applying this
 21 subparagraph).

22 “(B) OPEN ENROLLMENT PERIOD FOR
 23 CURRENT BENEFICIARIES IN WHICH LATE EN-
 24 ROLLMENT PROCEDURES DO NOT APPLY.—The
 25 Secretary shall establish an applicable period,

1 which shall begin on the date on which the Sec-
 2 retary first begins to accept elections for enroll-
 3 ment under this part, during which any eligible
 4 beneficiary may enroll under this part without
 5 the application of the late enrollment proce-
 6 dures established under subparagraph (A)(i).

7 “(3) PERIOD OF COVERAGE.—

8 “(A) IN GENERAL.—Except as provided in
 9 subparagraph (B), an eligible beneficiary’s cov-
 10 erage under the program under this part shall
 11 be effective for the period provided in section
 12 1838, as if that section applied to the program
 13 under this part.

14 “(B) OPEN ENROLLMENT.—An eligible
 15 beneficiary who enrolls under the program
 16 under this part pursuant to paragraph (2)(B)
 17 shall be entitled to the benefits under this part
 18 beginning on the first day of the month fol-
 19 lowing the month in which such enrollment oc-
 20 curs.

21 “(C) LIMITATION.—Coverage under this
 22 part shall not begin prior to January 1, 2003.

23 “(4) PART D COVERAGE TERMINATED BY TER-
 24 MINATION OF COVERAGE UNDER PARTS A AND B.—

1 “(A) IN GENERAL.—In addition to the
 2 causes of termination specified in section 1838,
 3 the Secretary shall terminate an individual’s
 4 coverage under this part if the individual is no
 5 longer enrolled in either part A or part B.

6 “(B) EFFECTIVE DATE.—The termination
 7 described in subparagraph (A) shall be effective
 8 on the effective date of termination of coverage
 9 under part A or (if later) under part B.

10 “(b) ENROLLMENT WITH ELIGIBLE ENTITY.—

11 “(1) PROCESS.—

12 “(A) IN GENERAL.—The Secretary shall
 13 establish a process through which an eligible
 14 beneficiary who is enrolled under this part but
 15 not enrolled in a Medicare+Choice plan offered
 16 by a Medicare+Choice organization shall make
 17 an annual election to enroll with any eligible en-
 18 tity that has been awarded a contract under
 19 this part and serves the geographic area in
 20 which the beneficiary resides.

21 “(B) RULES.—In establishing the process
 22 under subparagraph (A), the Secretary shall
 23 use rules similar to the rules for enrollment and
 24 disenrollment with a Medicare+Choice plan

1 under section 1851 (including special election
2 periods under subsection (e)(4) of such section).

3 “(2) MEDICARE+CHOICE ENROLLEES.—An eli-
4 gible beneficiary who is enrolled under this part and
5 enrolled in a Medicare+Choice plan offered by a
6 Medicare+Choice organization shall receive coverage
7 of covered outpatient drugs under this part through
8 such plan.

9 “(c) FIRST ENROLLMENT PERIOD.—The processes
10 developed under subsections (a) and (b) shall ensure that
11 eligible beneficiaries are permitted to enroll under this
12 part and with an eligible entity prior to January 1, 2003,
13 in order to ensure that coverage under this part is effective
14 as of such date.

15 “PROVIDING INFORMATION TO BENEFICIARIES

16 “SEC. 1860C. (a) ACTIVITIES.—

17 “(1) IN GENERAL.—The Secretary shall con-
18 duct activities that are designed to broadly dissemi-
19 nate information to eligible beneficiaries (and pro-
20 spective eligible beneficiaries) regarding the coverage
21 provided under this part.

22 “(2) SPECIAL RULE FOR FIRST ENROLLMENT
23 UNDER THE PROGRAM.—To the extent practicable,
24 the activities described in paragraph (1) shall ensure
25 that eligible beneficiaries are provided with such in-

1 formation at least 30 days prior to the first enroll-
2 ment period described in section 1860B(c).

3 “(b) REQUIREMENTS.—

4 “(1) IN GENERAL.—The activities described in
5 subsection (a) shall—

6 “(A) be similar to the activities performed
7 by the Secretary under section 1851(d);

8 “(B) be coordinated with the activities per-
9 formed by the Secretary under such section and
10 under section 1804; and

11 “(C) provide for the dissemination of infor-
12 mation comparing the eligible entities that are
13 available to eligible beneficiaries residing in an
14 area under this part.

15 “(2) COMPARATIVE INFORMATION.—The com-
16 parative information described in paragraph (1)(B)
17 shall include the following:

18 “(A) BENEFITS.—A comparison of the
19 benefits provided by each eligible entity, includ-
20 ing a comparison of the pharmacy networks
21 used by each eligible entity and the formularies
22 and appeals processes implemented by each en-
23 tity.

1 “(B) QUALITY AND PERFORMANCE.—To
2 the extent available, the quality and perform-
3 ance of each eligible entity.

4 “(C) BENEFICIARY COSTS.—The cost-shar-
5 ing required of eligible beneficiaries enrolled in
6 each eligible entity.

7 “(D) CONSUMER SATISFACTION SUR-
8 VEYS.—To the extent available, the results of
9 consumer satisfaction surveys regarding each
10 eligible entity.

11 “(E) ADDITIONAL INFORMATION.—Such
12 additional information as the Secretary may
13 prescribe.

14 “(3) INFORMATION STANDARDS.—The Sec-
15 retary shall develop standards to ensure that the in-
16 formation provided to eligible beneficiaries under
17 this part is complete, accurate, and uniform.

18 “(c) USE OF MEDICARE CONSUMER COALITIONS TO
19 PROVIDE INFORMATION.—

20 “(1) IN GENERAL.—The Secretary may con-
21 tract with Medicare Consumer Coalitions to conduct
22 the informational activities—

23 “(A) under this section;

24 “(B) under section 1851(d); and

25 “(C) under section 1804.

1 “(2) SELECTION OF COALITIONS.—If the Sec-
 2 retary determines the use of Medicare Consumer
 3 Coalitions to be appropriate, the Secretary shall—

4 “(A) develop and disseminate, in such
 5 areas as the Secretary determines appropriate,
 6 a request for proposals for Medicare Consumer
 7 Coalitions to contract with the Secretary in
 8 order to conduct any of the informational ac-
 9 tivities described in paragraph (1); and

10 “(B) select a proposal of a Medicare Con-
 11 sumer Coalition to conduct the informational
 12 activities in each such area, with a preference
 13 for broad participation by organizations with
 14 experience in providing information to bene-
 15 ficiaries under this title.

16 “(3) PAYMENT TO MEDICARE CONSUMER COA-
 17 LITIONS.—The Secretary shall make payments to
 18 Medicare Consumer Coalitions contracting under
 19 this subsection in such amounts and in such manner
 20 as the Secretary determines appropriate.

21 “(4) AUTHORIZATION OF APPROPRIATIONS.—
 22 There are authorized to be appropriated to the Sec-
 23 retary such sums as may be necessary to contract
 24 with Medicare Consumer Coalitions under this sec-
 25 tion.

8 “SEC. 1860D. (a) ANNUAL ESTABLISHMENT OF
9 MONTHLY PREMIUM RATES.—

15 “(2) ACTUARIAL DETERMINATIONS.—

“(A) DETERMINATION OF ANNUAL BENEFIT AND ADMINISTRATIVE COSTS.—The Secretary shall estimate annually for the succeeding year the amount equal to the total of the benefits and administrative costs that will be payable from the Federal Supplementary Medical Insurance Trust Fund for providing covered outpatient drugs in such calendar year with respect to enrollees in the program under this part.

1 “(B) DETERMINATION OF MONTHLY PRE-
2 MIUM RATES.—

3 “(i) IN GENERAL.—The Secretary
4 shall determine the monthly premium rate
5 with respect to such enrollees for such suc-
6 ceeding year, which shall be $\frac{1}{12}$ of the ap-
7 plicable share of the amount determined
8 under subparagraph (A), divided by the
9 total number of such enrollees, and round-
10 ed (if such rate is not a multiple of 10
11 cents) to the nearest multiple of 10 cents.

12 “(ii) DEFINITION OF APPLICABLE
13 SHARE.—For purposes of clause (i), the
14 term ‘applicable share’ means—

15 “(I) one-half, in the case of pre-
16 miums paid by an eligible beneficiary
17 enrolled in the program under this
18 part; and

19 “(II) two-thirds, in the case of
20 premiums paid for such a beneficiary
21 by an employer (as defined in section
22 1860I(e)(2)) that the beneficiary for-
23 merly worked for.

24 “(3) PUBLICATION OF ASSUMPTIONS.—The
25 Secretary shall publish, together with the promulga-

1 tion of the monthly premium rates for the suc-
 2 ceeding year, a statement setting forth the actuarial
 3 assumptions and bases employed in arriving at the
 4 amounts and rates determined under paragraphs (1)
 5 and (2).

6 “(b) COLLECTION OF PREMIUM.—The monthly pre-
 7 mium applicable to an eligible beneficiary under this part
 8 shall be collected and credited to the Federal Supple-
 9 mentary Medical Insurance Trust Fund in the same man-
 10 ner as the monthly premium determined under section
 11 1839 is collected and credited to such Trust Fund under
 12 section 1840.

13 “(c) INCREASE IN PREMIUM FOR HIGH-INCOME
 14 BENEFICIARIES.—

15 “(1) INCREASE.—

16 “(A) AMOUNT.—

17 “(i) IN GENERAL.—Except as pro-
 18 vided in paragraph (4), in the case of an
 19 eligible beneficiary whose modified ad-
 20 justed gross income for a taxable year end-
 21 ing with or within a calendar year (as ini-
 22 tially determined by the Secretary in ac-
 23 cordance with paragraph (2)) exceeds the
 24 threshold amount, the Secretary shall in-
 25 crease the amount of the monthly premium

1 established under subsection (a) by an
2 amount which bears the same ratio to such
3 premium as such excess bears to \$25,000
4 (or \$50,000 in the case of a joint return).

5 “(ii) LIMITATION.—In no event shall
6 the increase described in clause (i) exceed
7 an amount equal to 50 percent of the
8 monthly premium established under sub-
9 section (a).

10 “(B) DEFINITION OF THRESHOLD
11 AMOUNT.—For purposes of this subsection, the
12 term ‘threshold amount’ means—

13 “(i) except as otherwise provided in
14 this subparagraph, \$75,000;

15 “(ii) \$150,000 in the case of a joint
16 return; and

17 “(iii) zero in the case of a taxpayer
18 who—

19 “(I) is married at the close of the
20 taxable year but does not file a joint
21 return (as so defined) for such year;
22 and

23 “(II) does not live apart from his
24 spouse at all times during the taxable
25 year.

1 “(C) INFLATION ADJUSTMENT FOR
2 THRESHOLD AMOUNT.—

3 “(i) IN GENERAL.—In the case of any
4 calendar year beginning after 2003, each
5 of the dollar amounts in clauses (i) and (ii)
6 of subparagraph (B) shall be increased by
7 an amount equal to—

8 “(I) such dollar amount, multi-
9 plied by

10 “(II) the percentage (if any) by
11 which the average of the Consumer
12 Price Index for all urban consumers
13 (United States city average) for the
14 12-month period ending with June of
15 the preceding calendar year, exceeds
16 such average for the 12-month period
17 ending with June 2002.

18 “(ii) ROUNDING.—If any dollar
19 amount after being increased under clause
20 (i) is not a multiple of \$5, such dollar
21 amount shall be rounded to the nearest
22 multiple of \$5.

23 “(D) DEFINITION OF MODIFIED ADJUSTED
24 GROSS INCOME.—For purposes of this sub-
25 section, the term ‘modified adjusted gross in-

come’ means adjusted gross income (as defined in section 62 of the Internal Revenue Code of 1986)—

“(i) determined without regard to sections 135, 911, 931, and 933 of such Code; and

“(ii) increased by the amount of interest received or accrued by the taxpayer during the taxable year which is exempt from tax under such Code.

“(E) DEFINITION OF JOINT RETURN.—

For purposes of this subsection, the term ‘joint return’ has the meaning given the term in section 7701(a)(38) of the Internal Revenue Code of 1986.

“(2) DETERMINATION OF MODIFIED ADJUSTED

GROSS INCOME.—The Secretary shall make an initial determination of the amount of an eligible beneficiary’s modified adjusted gross income for a taxable year ending with or within a calendar year for purposes of this subsection as follows:

“(A) NOTICE.—Not later than September

1 of the year preceding the year, the Secretary shall provide notice to each eligible beneficiary whom the Secretary finds (on the basis of the

1 beneficiary's actual modified adjusted gross in-
2 come for the most recent taxable year for which
3 such information is available or other informa-
4 tion provided to the Secretary by the Secretary
5 of the Treasury) will be subject to an increase
6 under this subsection that the beneficiary will
7 be subject to such an increase, and shall include
8 in such notice the Secretary's estimate of the
9 beneficiary's modified adjusted gross income for
10 the year.

11 “(B) CALCULATION BASED ON INFORMA-
12 TION PROVIDED BY BENEFICIARY.—If, during
13 the 60-day period beginning on the date notice
14 is provided to an eligible beneficiary under sub-
15 paragraph (A), the beneficiary provides the Sec-
16 retary with appropriate information (as deter-
17 mined by the Secretary) on the beneficiary's an-
18 ticipated modified adjusted gross income for the
19 year, the amount initially determined by the
20 Secretary under this paragraph with respect to
21 the beneficiary shall be based on the informa-
22 tion provided by the beneficiary.

23 “(C) CALCULATION BASED ON NOTICE
24 AMOUNT IF NO INFORMATION IS PROVIDED BY
25 THE BENEFICIARY OR IF THE SECRETARY DE-

TERMINES THAT THE PROVIDED INFORMATION
 IN NOT APPROPRIATE.—The amount initially
 determined by the Secretary under this para-
 graph with respect to an eligible beneficiary
 shall be the amount included in the notice pro-
 vided to the beneficiary under subparagraph
 (A) if—

“(i) the beneficiary does not provide
 the Secretary with information under sub-
 paragraph (B); or

“(ii) the Secretary determines that
 the information provided by the beneficiary
 to the Secretary under such subparagraph
 is not appropriate.

“(3) ADJUSTMENTS.—

“(A) IN GENERAL.—If the Secretary deter-
 mines (on the basis of final information pro-
 vided by the Secretary of the Treasury) that
 the amount of an eligible beneficiary’s actual
 modified adjusted gross income for a taxable
 year ending with or within a calendar year is
 less than or greater than the amount initially
 determined by the Secretary under paragraph
 (2), the Secretary shall increase or decrease the
 amount of the beneficiary’s monthly premium

1 under this part (as the case may be) for months
2 during the following calendar year by an
3 amount equal to $\frac{1}{12}$ of the difference
4 between—

5 “(i) the total amount of all monthly
6 premiums paid by the beneficiary under
7 this part during the previous calendar
8 year; and

9 “(ii) the total amount of all such pre-
10 miums which would have been paid by the
11 beneficiary during the previous calendar
12 year if the amount of the beneficiary’s
13 modified adjusted gross income initially de-
14 termined under paragraph (2) were equal
15 to the actual amount of the beneficiary’s
16 modified adjusted gross income determined
17 under this paragraph.

18 “(B) INTEREST.—

19 “(i) INCREASE.—In the case of an eli-
20 gible beneficiary for whom the amount ini-
21 tially determined by the Secretary under
22 paragraph (2) is based on information pro-
23 vided by the beneficiary under subpara-
24 graph (B) of such paragraph, if the Sec-
25 retary determines under subparagraph (A)

1 that the amount of the beneficiary's actual
2 modified adjusted gross income for a tax-
3 able year is greater than the amount ini-
4 tially determined under paragraph (2), the
5 Secretary shall increase the amount other-
6 wise determined for the year under sub-
7 paragraph (A) by an amount of interest
8 equal to the sum of the amounts deter-
9 mined under clause (ii) for each of the
10 months described in such clause.

11 “(ii) COMPUTATION.—Interest shall
12 be computed for any month in an amount
13 determined by applying the underpayment
14 rate established under section 6621 of the
15 Internal Revenue Code of 1986 (com-
16 pounded daily) to any portion of the dif-
17 ference between the amount initially deter-
18 mined under paragraph (2) and the
19 amount determined under subparagraph
20 (A) for the period beginning on the first
21 day of the month beginning after the eligi-
22 ble beneficiary provided information to the
23 Secretary under subparagraph (B) of para-
24 graph (2) and ending 30 days before the
25 first month for which the beneficiary's

1 monthly premium is increased under this
2 paragraph.

3 “(iii) EXCEPTION.—Interest shall not
4 be imposed under this subparagraph if the
5 amount of the eligible beneficiary’s modi-
6 fied adjusted gross income provided by the
7 beneficiary under subparagraph (B) of
8 paragraph (2) was not less than the bene-
9 ficiary’s modified adjusted gross income
10 determined on the basis of information
11 shown on the return of tax imposed by
12 chapter 1 of the Internal Revenue Code of
13 1986 for the taxable year involved.

14 “(C) STEPS TO RECOVER AMOUNTS DUE
15 FROM PREVIOUSLY ENROLLED BENE-
16 FICIARIES.—In the case of an eligible bene-
17 ficiary who is not enrolled under this part for
18 any calendar year for which the beneficiary’s
19 monthly premium under this part for months
20 during the year would be increased pursuant to
21 subparagraph (A) if the beneficiary were en-
22 rolled under this part for the year, the Sec-
23 retary may take such steps as the Secretary
24 considers appropriate to recover from the bene-
25 ficiary the total amount by which the bene-

1 ficiary’s monthly premium under this part for
 2 months during the year would have been in-
 3 creased under subparagraph (A) if the bene-
 4 ficiary were enrolled under this part for the
 5 year.

6 “(D) DECEASED BENEFICIARY.—In the
 7 case of a deceased eligible beneficiary for whom
 8 the amount of the monthly premium under this
 9 part for months in a year would have been de-
 10 creased pursuant to subparagraph (A) if the
 11 beneficiary were not deceased, the Secretary
 12 shall make a payment to the beneficiary’s sur-
 13 viving spouse (or, in the case of an eligible ben-
 14 eficiary who does not have a surviving spouse,
 15 to the beneficiary’s estate) in an amount equal
 16 to the difference between—

17 “(i) the total amount by which the
 18 beneficiary’s premium would have been de-
 19 creased for all months during the year pur-
 20 suant to subparagraph (A); and

21 “(ii) the amount (if any) by which the
 22 beneficiary’s premium was decreased for
 23 months during the year pursuant to sub-
 24 paragraph (A).

1 “(4) WAIVER BY SECRETARY.—The Secretary
 2 may waive the imposition of all or part of the in-
 3 crease of the premium or all or part of any interest
 4 due under this subsection for any period if the Sec-
 5 retary determines that a gross injustice would other-
 6 wise result without such waiver.

7 “(5) TRANSFER TO PART B TRUST FUND.—The
 8 Secretary shall transfer amounts received pursuant
 9 to this subsection to the Federal Supplementary
 10 Medical Insurance Trust Fund.

11 “COST-SHARING

12 “SEC. 1860E. (a) DEDUCTIBLE.—

13 “(1) IN GENERAL.—Subject to paragraph (2),
 14 no payments shall be made under this part on behalf
 15 of an eligible beneficiary until the beneficiary has
 16 met a \$250 deductible.

17 “(2) WAIVER OF DEDUCTIBLE FOR GENERIC
 18 DRUGS.—

19 “(A) IN GENERAL.—An eligible entity may
 20 provide that generic drugs are not subject to
 21 the deductible described in paragraph (1) if the
 22 Secretary determines that the waiver of the
 23 deductible—

24 “(i) is tied to the performance meas-
 25 ures and other incentives applicable to the
 26 entity pursuant to section 1860H(a); and

1 “(ii) will not result in an increase in
 2 the expenditures made from the Federal
 3 Supplementary Medical Insurance Trust
 4 Fund.

5 “(B) CREDIT FOR AMOUNTS PAID.—If the
 6 deductible is waived pursuant to subparagraph
 7 (A), any coinsurance paid by an eligible bene-
 8 ficiary for the generic drug shall be credited to-
 9 ward the annual deductible.

10 “(b) COINSURANCE.—

11 “(1) ESTABLISHMENT.—

12 “(A) IN GENERAL.—Subject to paragraph
 13 (2), if any covered outpatient drug is provided
 14 to an eligible beneficiary in a year after the
 15 beneficiary has met any deductible requirement
 16 under subsection (a) for the year, the bene-
 17 ficiary shall be responsible for making payments
 18 for the drug in an amount equal to the applica-
 19 ble percentage of the cost of the drug.

20 “(B) APPLICABLE PERCENTAGE DE-
 21 FINED.—For purposes of subparagraph (A), the
 22 ‘applicable percentage’ means, with respect to
 23 any covered outpatient drug provided to an eli-
 24 gible beneficiary in a year—

1 “(i) 50 percent to the extent the out-
 2 of-pocket expenses of the beneficiary for
 3 such drug, when added to the out-of-pocket
 4 expenses of the beneficiary for covered out-
 5 patient drugs previously provided in the
 6 year, do not exceed \$3,500;

7 “(ii) 25 percent to the extent such ex-
 8 penses, when so added, exceed \$3,500 but
 9 do not exceed \$4,000; and

10 “(iii) 0 percent to the extent such ex-
 11 penses, when so added, would exceed
 12 \$4,000.

13 “(C) OUT-OF-POCKET EXPENSES DE-
 14 FINED.—For purposes of subparagraph (B),
 15 the term ‘out-of-pocket expenses’ means ex-
 16 penses incurred as a result of the application of
 17 the deductible under subsection (a) and the co-
 18 insurance required under this subsection.

19 “(2) REDUCTION BY ELIGIBLE ENTITY.—An el-
 20 igible entity may reduce the applicable percentage
 21 that an eligible beneficiary is subject to under para-
 22 graph (1) if the Secretary determines that such
 23 reduction—

7 “(c) INFLATION ADJUSTMENT.—

12 “(A) such dollar amount, multiplied by

17 “(2) ROUNDING.—If any dollar amount after
18 being increased under paragraph (1) is not a mul-
19 tiple of \$5, such dollar amount shall be rounded to
20 the nearest multiple of \$5.

22 DRUG BENEFIT

25 “(1) IN GENERAL.—The Secretary shall estab-
26 lish procedures under which the Secretary accepts

1 bids submitted by eligible entities and awards con-
 2 tracts to such entities in order to administer and de-
 3 liver the benefits provided under this part to eligible
 4 beneficiaries in an area.

5 “(2) COMPETITIVE PROCEDURES.—Competitive
 6 procedures (as defined in section 4(5) of the Office
 7 of Federal Procurement Policy Act (41 U.S.C.
 8 403(5))) shall be used to enter into contracts under
 9 this part.

10 “(b) AREA FOR CONTRACTS.—

11 “(1) REGIONAL BASIS.—

12 “(A) IN GENERAL.—Except as provided in
 13 subparagraph (B) and subject to paragraph (2),
 14 the contract entered into between the Secretary
 15 and an eligible entity shall require the eligible
 16 entity to provide covered outpatient drugs on a
 17 regional basis.

18 “(B) PARTIAL REGIONAL BASIS.—

19 “(i) IN GENERAL.—If determined ap-
 20 propriate by the Secretary, the Secretary
 21 may permit the coverage described in sub-
 22 paragraph (A) to be provided on a partial
 23 regional basis.

24 “(ii) REQUIREMENTS.—If the Sec-
 25 retary permits coverage pursuant to clause

(i), the Secretary shall ensure that the partial region in which coverage is provided is—

“(I) at least the size of the commercial service area of the eligible entity for that area; and

“(II) not smaller than a State.

“(2) DETERMINATION.—

“(A) IN GENERAL.—In determining coverage areas under this part, the Secretary shall—

“(i) take into account the number of eligible beneficiaries in an area in order to encourage participation by eligible entities; and

“(ii) ensure that there are at least 10 different coverage areas in the United States.

“(B) NO ADMINISTRATIVE OR JUDICIAL REVIEW.—The determination of coverage areas under this part shall not be subject to administrative or judicial review.

“(c) SUBMISSION OF BIDS.—

“(1) IN GENERAL.—Each eligible entity desiring to provide covered outpatient drugs under this

1 part shall submit a bid to the Secretary at such
 2 time, in such manner, and accompanied by such in-
 3 formation as the Secretary may reasonably require.

4 “(2) REQUIRED INFORMATION.—The bids de-
 5 scribed in paragraph (1) shall include—

6 “(A) a proposal for the estimated prices of
 7 covered outpatient drugs and the projected an-
 8 nual increases in such prices, including differen-
 9 tials between formulary and nonformulary
 10 prices, if applicable;

11 “(B) the amount that the entity will
 12 charge the Secretary for administering and de-
 13 livering the benefits under such contract;

14 “(C) a statement regarding whether the
 15 entity will waive the deductible for generic
 16 drugs pursuant to section 1860E(a)(2);

17 “(D) a statement regarding whether the
 18 entity will reduce the applicable coinsurance
 19 percentage pursuant to section 1860E(b)(2)
 20 and if so, the amount of such reduction;

21 “(E) a detailed description of—

22 “(i) the risk corridors tied to perform-
 23 ance measures and other incentives that
 24 the entity will accept under the contract;
 25 and

1 “(ii) how the entity will meet such
2 measures and incentives;

3 “(F) a detailed description of any owner-
4 ship or shared financial interests with other en-
5 tities involved in the delivery of the benefit as
6 proposed;

7 “(G) a detailed description of the entity’s
8 estimated marketing and advertising expendi-
9 tures related to enrolling and retaining eligible
10 beneficiaries; and

11 “(H) such other information that the Sec-
12 retary determines is necessary in order to carry
13 out this part, including information relating to
14 the bidding process under this part.

15 “(d) ACCESS.—

16 “(1) IN GENERAL.—The Secretary shall ensure
17 that an eligible entity—

18 “(A) complies with the access requirements
19 described in section 1860G(4)(A); and

20 “(B) makes available to each beneficiary
21 covered under the contract the full scope of the
22 benefits required under this part.

23 “(2) AREAS NOT COVERED BY CONTRACTS.—
24 The Secretary shall develop procedures for the provi-
25 sion of covered outpatient drugs under this part to

1 each eligible beneficiary that resides in an area that
2 is not covered by any contract under this part.

3 “(3) BENEFICIARIES RESIDING IN DIFFERENT
4 LOCATIONS.—The Secretary shall develop procedures
5 to ensure that each eligible beneficiary that resides
6 in different areas in a year is provided the benefits
7 under this part throughout the entire year.

8 “(e) AWARDING OF CONTRACTS.—

9 “(1) NUMBER OF CONTRACTS.—The Secretary
10 shall, consistent with the requirements of this part
11 and the goal of containing costs under this title,
12 award in a competitive manner at least 2 contracts
13 in an area, unless only 1 bidding entity meets the
14 minimum standards specified under this part and by
15 the Secretary.

16 “(2) DETERMINATION.—In determining which
17 of the eligible entities that submitted bids that meet
18 the minimum standards specified under this part
19 and by the Secretary (including the terms and condi-
20 tions described in section 1860G) to award a con-
21 tract, the Secretary shall consider the comparative
22 merits of each bid, as determined on the basis of the
23 past performance of the entity and other relevant
24 factors, with respect to—

1 “(A) how well the entity meets such min-
2 imum standards;

3 “(B) the amount that the entity will
4 charge the Secretary for administering and de-
5 livering the benefits under the contract;

6 “(C) the proposed prices of covered out-
7 patient drugs and annual increases in such
8 prices;

9 “(D) the proposed risk corridors tied to
10 performance measures and other incentives that
11 the entity will be subject to under the contract;

12 “(E) the factors described in section
13 1860C(b)(2);

14 “(F) prior experience in administering a
15 prescription drug benefit program;

16 “(G) effectiveness in containing costs
17 through pricing incentives and utilization man-
18 agement; and

19 “(H) such other factors as the Secretary
20 deems necessary to evaluate the merits of each
21 bid.

22 “(3) EXCEPTION TO CONFLICT OF INTEREST
23 RULES.—In awarding contracts under this part, the
24 Secretary may waive conflict of interest laws gen-
25 erally applicable to Federal acquisitions (subject to

1 such safeguards as the Secretary may find necessary
 2 to impose) in circumstances where the Secretary
 3 finds that such waiver—

4 “(A) is not inconsistent with the—

5 “(i) purposes of the programs under
 6 this title; or

7 “(ii) best interests of enrolled individ-
 8 uals; and

9 “(B) permits a sufficient level of competi-
 10 tion for such contracts, promotes efficiency of
 11 benefits administration, or otherwise serves the
 12 objectives of the program under this part.

13 “(4) NO ADMINISTRATIVE OR JUDICIAL RE-
 14 VIEW.—The determination of the Secretary to award
 15 or not award a contract to an eligible entity under
 16 this part shall not be subject to administrative or ju-
 17 dicial review.

18 “(f) APPROVAL OF MARKETING MATERIAL AND AP-
 19 PLICATION FORMS.—The provisions of section 1851(h)
 20 shall apply to marketing material and application forms
 21 under this part in the same manner as such provisions
 22 apply to marketing material and application forms under
 23 part C.

24 “(g) DURATION OF CONTRACTS.—Each contract
 25 under this part shall be for a term of at least 2 years

1 but not more than 5 years, as determined by the Sec-
 2 retary.

3 “CONDITIONS FOR AWARDING CONTRACT

4 “SEC. 1860G. The Secretary shall not award a con-
 5 tract to an eligible entity under this part unless the Sec-
 6 retary finds that the eligible entity agrees to comply with
 7 such terms and conditions as the Secretary shall specify,
 8 including the following:

9 “(1) QUALITY AND FINANCIAL STANDARDS.—

10 The eligible entity meets the quality and financial
 11 standards specified by the Secretary.

12 “(2) PROCEDURES TO ENSURE PROPER UTILI-
 13 ZATION, COMPLIANCE, AND AVOIDANCE OF ADVERSE
 14 DRUG REACTIONS.—The eligible entity has in place
 15 drug utilization review procedures to ensure—

16 “(A) the appropriate utilization by eligible
 17 beneficiaries of the benefits to be provided
 18 under the contract; and

19 “(B) the avoidance of adverse drug reac-
 20 tions among eligible beneficiaries enrolled with
 21 the entity, including problems due to thera-
 22 peutic duplication, drug-disease contraindica-
 23 tions, drug-drug interactions (including serious
 24 interactions with nonprescription or over-the-
 25 counter drugs), incorrect drug dosage or dura-

1 tion of drug treatment, drug-allergy inter-
2 actions, and clinical abuse and misuse.

3 “(3) COST-EFFECTIVE PROVISION OF BENE-
4 FITS.—

5 “(A) IN GENERAL.—In providing the bene-
6 fits under a contract under this part, an eligible
7 entity may—

8 “(i) employ mechanisms to provide
9 the benefits economically, including the use
10 of—

11 “(I) formularies (pursuant to
12 subparagraph (B));

13 “(II) alternative methods of dis-
14 tribution; and

15 “(III) generic drug substitution;

16 “(ii) use mechanisms to encourage eli-
17 gible beneficiaries to select cost-effective
18 drugs or less costly means of receiving
19 drugs, including the use of pharmacy in-
20 centive programs, therapeutic interchange
21 programs, and disease management pro-
22 grams; and

23 “(iii) encourage pharmacy providers
24 to—

1 “(I) inform beneficiaries of the
2 differentials in price between generic
3 and nongeneric drug equivalents; and

4 “(II) provide medication therapy
5 management programs in order to en-
6 hance beneficiaries’ understanding of
7 the appropriate use of medications
8 and to reduce the risk of potential ad-
9 verse events associated with medica-
10 tions.

11 “(B) FORMULARIES.—If an eligible entity
12 uses a formulary under this part, such for-
13 mulary shall comply with standards established
14 by the Secretary in consultation with the Medi-
15 care Pharmacy and Therapeutics Advisory
16 Committee established under section 1860M.
17 Such standards shall require that the eligible
18 entity—

19 “(i) use a pharmacy and therapeutic
20 committee (that meets the standards for a
21 pharmacy and therapeutic committee es-
22 tablished by the Secretary in consultation
23 with the Medicare Pharmacy and Thera-
24 peutics Advisory Committee established

1 under section 1860M) to develop and im-
2 plement the formulary;

3 “(ii) include in the formulary—

4 “(I) at least 1 drug from each
5 therapeutic class (as defined by the
6 entity’s pharmacy and therapeutic
7 committee in accordance with stand-
8 ards established by the Secretary in
9 consultation with the Medicare Phar-
10 macy and Therapeutics Advisory
11 Committee established under section
12 1860M);

13 “(II) if there is more than 1 drug
14 available in a therapeutic class, at
15 least 2 drugs from such class; and

16 “(III) if there is more than 2
17 drugs available in a therapeutic class,
18 at least 2 drugs from such class and
19 a generic drug substitute if available;

20 “(iii) develop procedures for the—

21 “(I) addition of new therapeutic
22 classes to the formulary;

23 “(II) addition of new drugs to an
24 existing therapeutic class; and

1 “(III) modification of the for-
2 mulary;

3 “(iv) provide for coverage of nonfor-
4 mulary drugs when determined (pursuant
5 to subparagraph (C) or (D)(i) of para-
6 graph (4)) to be medically necessary to
7 prevent or slow the deterioration of, or im-
8 prove or maintain, the health of an eligible
9 beneficiary; and

10 “(v) disclose to current and prospec-
11 tive beneficiaries and to providers in the
12 service area the nature of the formulary
13 restrictions, including information regard-
14 ing the drugs included in the formulary,
15 coinsurance, and any difference in the
16 cost-sharing for different types of drugs.

17 “(C) CONSTRUCTION.—Nothing in this
18 paragraph shall be construed as precluding an
19 eligible entity from—

20 “(i) requiring cost-sharing for nonfor-
21 mulary drugs that is higher than the cost-
22 sharing established in section 1860E(b),
23 except that such entity shall provide for
24 coverage of a nonformulary drug at the
25 same cost-sharing level as a drug within

the formulary if such nonformulary drug is determined (pursuant to subparagraph (C) or (D)(i) of paragraph (4)) to be medically necessary to prevent or slow the deterioration of, or improve or maintain, the health of an eligible beneficiary;

“(ii) educating prescribing providers, pharmacists, and beneficiaries about the medical and cost benefits of formulary drugs (including generic drugs); or

“(iii) requesting prescribing providers to consider a formulary drug prior to dispensing of a nonformulary drug, as long as such request does not unduly delay the provision of the drug.

“(4) PATIENT PROTECTIONS.—

“(A) ACCESS.—The eligible entity ensures that the covered outpatient drugs are accessible and convenient to eligible beneficiaries covered under the contract, including by offering the services in the following manner:

“(i) SERVICES DURING EMERGENCIES.—The offering of services 24 hours a day and 7 days a week for emergencies.

1 “(ii) CONTRACTS WITH RETAIL PHAR-
2 MACIES.—The offering of services—

3 “(I) at a sufficient number (as
4 determined by the Secretary) of retail
5 pharmacies;

6 “(II) to the extent feasible, at re-
7 tail pharmacies located throughout
8 the eligible entity’s service area to en-
9 sure reasonable geographic access (as
10 determined by the Secretary) to such
11 services; and

12 “(III) such that—

13 “(aa) the total charge for
14 each covered outpatient drug dis-
15 pensed to an eligible beneficiary
16 enrolled with the entity does not
17 exceed the negotiated price for
18 the drug (as reported to the Sec-
19 retary pursuant to paragraph
20 (6)(A)); and

21 “(bb) the retail pharmacy
22 dispensing the drug does not
23 charge (or collect from) such
24 beneficiary an amount that ex-
25 ceeds the beneficiary’s obligation

1 (as determined in accordance
2 with the provisions of this part)
3 of the negotiated price.

4 “(B) CONTINUITY OF CARE.—

5 “(i) IN GENERAL.—The eligible entity
6 ensures that, in the case of an eligible ben-
7 eficiary who loses coverage under this part
8 with such entity under circumstances that
9 would permit a special election period (as
10 established by the Secretary under section
11 1860B(b)), the entity will continue to pro-
12 vide coverage under this part to such bene-
13 ficiary until the beneficiary enrolls and re-
14 ceives such coverage with another eligible
15 entity under this part.

16 “(ii) LIMITED PERIOD.—In no event
17 shall an eligible entity be required to pro-
18 vide the extended coverage required under
19 clause (i) beyond the date which is 30 days
20 after the coverage with such entity would
21 have terminated but for this subparagraph.

22 “(C) PROCEDURES REGARDING THE DE-
23 TERMINATION OF DRUGS THAT ARE MEDICALLY
24 NECESSARY.—The eligible entity has in place
25 procedures to determine if a drug is medically

1 necessary to prevent or slow the deterioration
 2 of, or improve or maintain, the health of an eli-
 3 gible beneficiary. Such procedures shall require
 4 that such determinations are based on profes-
 5 sional medical judgment, the medical condition
 6 of the beneficiary, and other medical evidence.

7 “(D) PROCEDURES REGARDING DENIALS
 8 OF CARE.—The eligible entity has in place pro-
 9 cedures to ensure—

10 “(i) a timely internal and external re-
 11 view and resolution of denials of coverage
 12 (in whole or in part) and complaints (in-
 13 cluding those regarding the use of
 14 formularies under paragraph (3)) by eligi-
 15 ble beneficiaries, or by providers, phar-
 16 macists, and other individuals acting on
 17 behalf of each such beneficiary (with the
 18 beneficiary’s consent) in accordance with
 19 requirements (as established by the Sec-
 20 retary) that are comparable to such re-
 21 quirements for Medicare+Choice organiza-
 22 tions under part C; and

23 “(ii) that beneficiaries are provided
 24 with information regarding the appeals

1 procedures under this part at the time of
2 enrollment.

3 “(E) PROCEDURES REGARDING PATIENT
4 CONFIDENTIALITY.—Insofar as an eligible enti-
5 ty maintains individually identifiable medical
6 records or other health information regarding
7 eligible beneficiaries under a contract entered
8 into under this part, the entity has in place pro-
9 cedures to—

10 “(i) safeguard the privacy of any indi-
11 vidually identifiable beneficiary informa-
12 tion;

13 “(ii) maintain such records and infor-
14 mation in a manner that is accurate and
15 timely;

16 “(iii) ensure timely access by such
17 beneficiaries to such records and informa-
18 tion; and

19 “(iv) otherwise comply with applicable
20 laws relating to patient confidentiality.

21 “(F) PROCEDURES REGARDING TRANSFER
22 OF MEDICAL RECORDS.—

23 “(i) IN GENERAL.—The eligible entity
24 has in place procedures for the timely
25 transfer of records and information de-

scribed in subparagraph (E) (with respect to a beneficiary who loses coverage under this part with the entity and enrolls with another entity under this part) to such other entity.

“(ii) PATIENT CONFIDENTIALITY.—

The procedures described in clause (i) shall comply with the patient confidentiality procedures described in subparagraph (E).

“(G) PROCEDURES REGARDING MEDICAL

ERRORS.—The eligible entity has in place procedures for working with the Secretary to deter medical errors related to the provision of covered outpatient drugs.

“(5) PROCEDURES TO CONTROL FRAUD, ABUSE,

AND WASTE.—The eligible entity has in place procedures to control fraud, abuse, and waste.

“(6) REPORTING REQUIREMENTS.—

“(A) IN GENERAL.—The eligible entity provides the Secretary with reports containing information regarding the following:

“(i) The prices that the eligible entity is paying for covered outpatient drugs.

1 “(ii) The prices that eligible bene-
 2 ficiaries enrolled with the entity will be
 3 charged for covered outpatient drugs.

4 “(iii) The administrative costs of pro-
 5 viding such benefits.

6 “(iv) Utilization of such benefits.

7 “(v) Marketing and advertising ex-
 8 penditures related to enrolling and retain-
 9 ing eligible beneficiaries.

10 “(B) TIMEFRAME FOR SUBMITTING RE-
 11 PORTS.—

12 “(i) IN GENERAL.—The eligible entity
 13 shall submit a report described in subpara-
 14 graph (A) to the Secretary within 3
 15 months after the end of each 12-month pe-
 16 riod in which the eligible entity has a con-
 17 tract under this part. Such report shall
 18 contain information concerning the benefits
 19 provided during such 12-month period.

20 “(ii) LAST YEAR OF CONTRACT.—In
 21 the case of the last year of a contract
 22 under this section, the Secretary may re-
 23 quire that a report described in subpara-
 24 graph (A) be submitted 3 months prior to
 25 the end of the contract. Such report shall

1 contain information concerning the benefits
2 provided between the period covered by the
3 most recent report under this subpara-
4 graph and the date that a report is sub-
5 mitted under this clause.

6 “(C) CONFIDENTIALITY OF INFORMA-
7 TION.—

8 “(i) IN GENERAL.—Notwithstanding
9 any other provision of law and subject to
10 clause (ii), information disclosed by an eli-
11 gible entity pursuant to subparagraph (A)
12 is confidential and shall only be used by
13 the Secretary for the purposes of, and to
14 the extent necessary, to carry out this
15 part.

16 “(ii) UTILIZATION DATA.—Subject to
17 patient confidentiality laws, the Secretary
18 shall make information disclosed by an eli-
19 gible entity pursuant to subparagraph
20 (A)(iv) (regarding utilization data) avail-
21 able for research purposes. The Secretary
22 may charge a reasonable fee for making
23 such information available.

24 “(7) APPROVAL OF MARKETING MATERIAL AND
25 APPLICATION FORMS.—The eligible entity will com-

1 ply with the requirements described in section
2 1860F(f).

3 “(8) RECORDS AND AUDITS.—The eligible enti-
4 ty maintains adequate records related to the admin-
5 istration of the benefit under this part and affords
6 the Secretary access to such records for auditing
7 purposes.

8 “PAYMENTS

9 “SEC. 1860H. (a) PAYMENTS TO ELIGIBLE ENTI-
10 TIES.—

11 “(1) PROCEDURES.—

12 “(A) IN GENERAL.—The Secretary shall
13 establish procedures for making payments to an
14 eligible entity under a contract entered into
15 under this part for the administration and de-
16 livery of the benefits under this part.

17 “(B) ENTITIES ONLY SUBJECT TO LIM-
18 ITED RISK.—Under the procedures established
19 under subparagraph (A), an eligible entity shall
20 only be at risk to the extent that the entity is
21 at risk under paragraph (2).

22 “(2) RISK CORRIDORS TIED TO PERFORMANCE
23 MEASURES AND OTHER INCENTIVES.—

24 “(A) IN GENERAL.—The procedures estab-
25 lished under paragraph (1) may include the use
26 of—

1 “(i) risk corridors tied to performance
 2 measures that have been agreed to between
 3 the eligible entity and the Secretary under
 4 the contract; and

5 “(ii) any other incentives that the
 6 Secretary determines appropriate.

7 “(B) PHASE-IN OF RISK CORRIDORS TIED
 8 TO PERFORMANCE MEASURES.—The Secretary
 9 may phase-in the use of risk corridors tied to
 10 performance measures if the Secretary deter-
 11 mines such phase-in to be appropriate.

12 “(C) PAYMENTS SUBJECT TO INCEN-
 13 TIVES.—If a contract under this part includes
 14 the use of risk corridors tied to performance
 15 measures or other incentives pursuant to sub-
 16 paragraph (A), payments to eligible entities
 17 under such contract shall be subject to such
 18 risk corridors tied to performance measures and
 19 other incentives.

20 “(3) RISK ADJUSTMENT.—To the extent that
 21 eligible entities are at risk because of the risk cor-
 22 ridors or other incentives described in paragraph
 23 (2)(A), the procedures established under paragraph
 24 (1) may include a methodology for adjusting the
 25 payments made to such entities based on the dif-

1 ferences in actuarial risk of different enrollees being
 2 served if the Secretary determines such adjustments
 3 to be necessary and appropriate.

4 “(b) SECONDARY PAYER PROVISIONS.—The provi-
 5 sions of section 1862(b) shall apply to the benefits pro-
 6 vided under this part.

7 “EMPLOYER INCENTIVE PROGRAM FOR EMPLOYMENT-
 8 BASED RETIREE DRUG COVERAGE

9 “SEC. 1860I. (a) PROGRAM AUTHORITY.—The Sec-
 10 retary is authorized to develop and implement a program
 11 under this section called the ‘Employer Incentive Pro-
 12 gram’ that encourages employers and other sponsors of
 13 employment-based health care coverage to provide ade-
 14 quate prescription drug benefits to retired individuals by
 15 subsidizing, in part, the sponsor’s cost of providing cov-
 16 erage under qualifying plans.

17 “(b) SPONSOR REQUIREMENTS.—In order to be eligi-
 18 ble to receive an incentive payment under this section with
 19 respect to coverage of an individual under a qualified re-
 20 tiree prescription drug plan (as defined in subsection
 21 (f)(3)), a sponsor shall meet the following requirements:

22 “(1) ASSURANCES.—The sponsor shall—

23 “(A) annually attest, and provide such as-
 24 surances as the Secretary may require, that the
 25 coverage offered by the sponsor is a qualified
 26 retiree prescription drug plan, and will remain

1 such a plan for the duration of the sponsor's
2 participation in the program under this section;
3 and

4 “(B) guarantee that it will give notice to
5 the Secretary and covered retirees—

6 “(i) at least 120 days before termi-
7 nating its plan; and

8 “(ii) immediately upon determining
9 that the actuarial value of the prescription
10 drug benefit under the plan falls below the
11 actuarial value of the outpatient prescrip-
12 tion drug benefit under this part.

13 “(2) BENEFICIARY INFORMATION.—The spon-
14 sor shall report to the Secretary, for each calendar
15 quarter for which it seeks an incentive payment
16 under this section, the names and social security
17 numbers of all retirees (and their spouses and de-
18 pendents) covered under such plan during such
19 quarter and the dates (if less than the full quarter)
20 during which each such individual was covered.

21 “(3) AUDITS.—The sponsor and the employ-
22 ment-based retiree health coverage plan seeking in-
23 centive payments under this section shall agree to
24 maintain, and to afford the Secretary access to, such
25 records as the Secretary may require for purposes of

1 audits and other oversight activities necessary to en-
2 sure the adequacy of prescription drug coverage, the
3 accuracy of incentive payments made, and such
4 other matters as may be appropriate.

5 “(4) OTHER REQUIREMENTS.—The sponsor
6 shall provide such other information, and comply
7 with such other requirements, as the Secretary may
8 find necessary to administer the program under this
9 section.

10 “(c) INCENTIVE PAYMENTS.—

11 “(1) IN GENERAL.—A sponsor that meets the
12 requirements of subsection (b) with respect to a
13 quarter in a calendar year shall be entitled to have
14 payment made by the Secretary on a quarterly basis
15 (to the sponsor or, at the sponsor’s direction, to the
16 appropriate employment-based health plan) of an in-
17 centive payment, in the amount determined in para-
18 graph (2), for each retired individual (or spouse)
19 who—

20 “(A) was covered under the sponsor’s
21 qualified retiree prescription drug plan during
22 such quarter; and

23 “(B) was eligible for but was not enrolled
24 in the outpatient prescription drug benefit pro-
25 gram under this part.

1 “(2) AMOUNT OF INCENTIVE.—The payment
2 under this section with respect to each individual de-
3 scribed in paragraph (1) for a month shall be equal
4 to $\frac{2}{3}$ of the monthly premium amount payable by an
5 eligible beneficiary enrolled under this part, as set
6 for the calendar year pursuant to section
7 1860D(a)(2).

8 “(3) PAYMENT DATE.—The incentive under
9 this section with respect to a calendar quarter shall
10 be payable as of the end of the next succeeding cal-
11 endar quarter.

12 “(d) CIVIL MONEY PENALTIES.—A sponsor, health
13 plan, or other entity that the Secretary determines has,
14 directly or through its agent, provided information in con-
15 nection with a request for an incentive payment under this
16 section that the entity knew or should have known to be
17 false shall be subject to a civil monetary penalty in an
18 amount up to 3 times the total incentive amounts under
19 subsection (c) that were paid (or would have been payable)
20 on the basis of such information.

21 “(e) DEFINITIONS.—In this section:

22 “(1) EMPLOYMENT-BASED RETIREE HEALTH
23 COVERAGE.—The term ‘employment-based retiree
24 health coverage’ means health insurance or other
25 coverage of health care costs for retired individuals

1 (or for such individuals and their spouses and de-
2 pendants) based on their status as former employees
3 or labor union members.

4 “(2) EMPLOYER.—The term ‘employer’ has the
5 meaning given the term in section 3(5) of the Em-
6 ployee Retirement Income Security Act of 1974 (ex-
7 cept that such term shall include only employers of
8 2 or more employees).

9 “(3) QUALIFIED RETIREE PRESCRIPTION DRUG
10 PLAN.—The term ‘qualified retiree prescription drug
11 plan’ means health insurance coverage included in
12 employment-based retiree health coverage that—

13 “(A) provides coverage of the cost of pre-
14 scription drugs whose actuarial value (as de-
15 fined by the Secretary) to each retired bene-
16 ficiary equals or exceeds the actuarial value of
17 the benefits provided to an individual enrolled
18 in the outpatient prescription drug benefit pro-
19 gram under this part; and

20 “(B) does not deny, limit, or condition the
21 coverage or provision of prescription drug bene-
22 fits for retired individuals based on age or any
23 health status-related factor described in section
24 2702(a)(1) of the Public Health Service Act.

1 “(4) SPONSOR.—The term ‘sponsor’ has the
2 meaning given the term ‘plan sponsor’ in section
3 3(16)(B) of the Employer Retirement Income Secu-
4 rity Act of 1974.

5 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
6 are authorized to be appropriated from time to time, out
7 of any moneys in the Treasury not otherwise appropriated,
8 such sums as may be necessary to carry out the program
9 under this section.

10 “APPROPRIATIONS

11 “SEC. 1860J. There are authorized to be appro-
12 priated from time to time, out of any moneys in the Treas-
13 ury not otherwise appropriated, to the Federal Supple-
14 mentary Medical Insurance Trust Fund established under
15 section 1841, an amount equal to the amount by which
16 the benefits and administrative costs of providing the ben-
17 efits under this part exceed the premiums collected under
18 section 1860D.

19 “SUBPART 2—MEDICARE PHARMACY AND
20 THERAPEUTICS (P&T) ADVISORY COMMITTEE

21 “MEDICARE PHARMACY AND THERAPEUTICS (P&T)
22 ADVISORY COMMITTEE

23 “SEC. 1860M. (a) ESTABLISHMENT OF COM-
24 MITTEE.—There is established a Medicare Pharmacy and
25 Therapeutics Advisory Committee (in this section referred
26 to as the ‘Committee’).

1 “(b) FUNCTIONS OF COMMITTEE.—On and after Oc-
2 tober 1, 2001, the Committee shall advise the Secretary
3 on policies related to—

4 “(1) the development of guidelines for the im-
5 plementation and administration of the outpatient
6 prescription drug benefit program under this part;
7 and

8 “(2) the development of—

9 “(A) standards for a pharmacy and thera-
10 peutics committee required of eligible entities
11 under section 1860G(3)(B)(i);

12 “(B) procedures required of eligible enti-
13 ties under subparagraphs (C) and (D) of sec-
14 tion 1860G(4) for determining if a drug is
15 medically necessary to prevent or slow the dete-
16 rioration of, or improve or maintain, the health
17 of an eligible beneficiary;

18 “(C) standards for—

19 “(i) defining therapeutic classes;

20 “(ii) adding new therapeutic classes to
21 a formulary;

22 “(iii) adding new drugs to a thera-
23 peutic class within a formulary; and

24 “(iv) when and how often a formulary
25 should be modified;

1 “(D) procedures to evaluate the bids sub-
2 mitted by eligible entities under this part; and

3 “(E) procedures to ensure that eligible en-
4 tities with a contract under this part are in
5 compliance with the requirements under this
6 part.

7 “(c) STRUCTURE AND MEMBERSHIP OF THE COM-
8 MITTEE.—

9 “(1) STRUCTURE.—The Committee shall be
10 composed of 19 members who shall be appointed by
11 the Secretary.

12 “(2) MEMBERSHIP.—

13 “(A) IN GENERAL.—The members of the
14 Committee shall be chosen on the basis of their
15 integrity, impartiality, and good judgment, and
16 shall be individuals who are, by reason of their
17 education, experience, and attainments, excep-
18 tionally qualified to perform the duties of mem-
19 bers of the Committee.

20 “(B) SPECIFIC MEMBERS.—Of the mem-
21 bers appointed under paragraph (1)—

22 “(i) eleven shall be chosen to rep-
23 resent physicians;

24 “(ii) four shall be chosen to represent
25 pharmacists;

1 “(iii) one shall be chosen to represent
2 the Health Care Financing Administration;

3 “(iv) two shall be chosen to represent
4 actuaries and pharmacoeconomists; and

5 “(v) one shall be chosen to represent
6 emerging drug technologies.

7 “(d) TERMS OF APPOINTMENT.—Each member of
8 the Committee shall serve for a term determined appro-
9 priate by the Secretary. The terms of service of the mem-
10 bers initially appointed shall begin on January 1, 2001.

11 “(e) CHAIRMAN.—The Secretary shall designate a
12 member of the Committee as Chairman. The term as
13 Chairman shall be for a 1-year period.

14 “(f) COMPENSATION AND TRAVEL EXPENSES.—

15 “(1) COMPENSATION OF MEMBERS.—Each
16 member of the Committee who is not an officer or
17 employee of the Federal Government shall be com-
18 pensated at a rate equal to the daily equivalent of
19 the annual rate of basic pay prescribed for level IV
20 of the Executive Schedule under section 5315 of title
21 5, United States Code, for each day (including travel
22 time) during which such member is engaged in the
23 performance of the duties of the Committee. All
24 members of the Committee who are officers or em-
25 ployees of the United States shall serve without com-

1 pensation in addition to that received for their serv-
2 ices as officers or employees of the United States.

3 “(2) TRAVEL EXPENSES.—The members of the
4 Committee shall be allowed travel expenses, includ-
5 ing per diem in lieu of subsistence, at rates author-
6 ized for employees of agencies under subchapter I of
7 chapter 57 of title 5, United States Code, while
8 away from their homes or regular places of business
9 in the performance of services for the Committee.

10 “(g) OPERATION OF THE COMMITTEE.—

11 “(1) MEETINGS.—The Committee shall meet at
12 the call of the Chairman (after consultation with the
13 other members of the Committee) not less often
14 than quarterly to consider a specific agenda of
15 issues, as determined by the Chairman after such
16 consultation.

17 “(2) QUORUM.—Ten members of the Com-
18 mittee shall constitute a quorum for purposes of
19 conducting business.

20 “(h) FEDERAL ADVISORY COMMITTEE ACT.—Section
21 14 of the Federal Advisory Committee Act (5 U.S.C.
22 App.) shall not apply to the Committee.

23 “(i) TRANSFER OF PERSONNEL, RESOURCES, AND
24 ASSETS.—For purposes of carrying out its duties, the Sec-
25 retary and the Committee may provide for the transfer

1 to the Committee of such civil service personnel in the em-
 2 ploy of the Department of Health and Human Services,
 3 and such resources and assets of the Department used in
 4 carrying out this title, as the Committee requires.

5 “(j) AUTHORIZATION OF APPROPRIATIONS.—There
 6 are authorized to be appropriated such sums as may be
 7 necessary to carry out the purposes of this section.”.

8 (b) EXCLUSIONS FROM COVERAGE.—

9 (1) APPLICATION TO PART D.—Section 1862(a)
 10 of the Social Security Act (42 U.S.C. 1395y(a)) is
 11 amended in the matter preceding paragraph (1) by
 12 striking “part A or part B” and inserting “part A,
 13 B, or D”.

14 (2) PRESCRIPTION DRUGS NOT EXCLUDED
 15 FROM COVERAGE IF REASONABLE AND NEC-
 16 ESSARY.—Section 1862(a)(1) of the Social Security
 17 Act (42 U.S.C. 1395y(a)(1)) is amended—

18 (A) in subparagraph (H), by striking
 19 “and” at the end;

20 (B) in subparagraph (I), by striking the
 21 semicolon at the end and inserting “, and”; and

22 (C) by adding at the end the following new
 23 subparagraph:

24 “(J) in the case of prescription drugs cov-
 25 ered under part D, which are not reasonable

1 and necessary to prevent or slow the deteriora-
 2 tion of, or improve or maintain, the health of
 3 eligible beneficiaries;”.

4 (c) CONFORMING REFERENCES TO PREVIOUS PART
 5 D.—

6 (1) IN GENERAL.—Any reference in law (in ef-
 7 fect before the date of enactment of this Act) to part
 8 D of title XVIII of the Social Security Act is deemed
 9 a reference to part E of such title (as in effect after
 10 such date).

11 (2) SECRETARIAL SUBMISSION OF LEGISLATIVE
 12 PROPOSAL.—Not later than 6 months after the date
 13 of enactment of this Act, the Secretary of Health
 14 and Human Services shall submit to the appropriate
 15 committees of Congress a legislative proposal pro-
 16 viding for such technical and conforming amend-
 17 ments in the law as are required by the provisions
 18 of this Act.

19 **SEC. 3. PART D BENEFITS UNDER MEDICARE+CHOICE**
 20 **PLANS.**

21 (a) ELIGIBILITY, ELECTION, AND ENROLLMENT.—
 22 Section 1851 of the Social Security Act (42 U.S.C.
 23 1395w-21) is amended—

24 (1) in subsection (a)(1)(A), by striking “parts
 25 A and B” and inserting “parts A, B, and D”; and

1 (2) in subsection (i)(1), by striking “parts A
2 and B” and inserting “parts A, B, and D”.

3 (b) VOLUNTARY BENEFICIARY ENROLLMENT FOR
4 DRUG COVERAGE.—Section 1852(a)(1)(A) of such Act
5 (42 U.S.C. 1395w–22(a)(1)(A)) is amended by inserting
6 “(and under part D to individuals also enrolled under that
7 part)” after “parts A and B”.

8 (c) ACCESS TO SERVICES.—Section 1852(d)(1) of
9 such Act (42 U.S.C. 1395w–22(d)(1)) is amended—

10 (1) in subparagraph (D), by striking “and” at
11 the end;

12 (2) in subparagraph (E), by striking the period
13 at the end and inserting “; and”; and

14 (3) by adding at the end the following new sub-
15 paragraph:

16 “(F) in the case of covered outpatient
17 drugs provided to individuals enrolled under
18 part D (as defined in section 1860(1)), the or-
19 ganization complies with the access require-
20 ments applicable under part D.”.

21 (d) PAYMENTS TO ORGANIZATIONS.—Section
22 1853(a)(1)(A) of such Act (42 U.S.C. 1395w–
23 23(a)(1)(A)) is amended—

24 (1) by inserting “determined separately for the
25 benefits under parts A and B and under part D (for

1 individuals enrolled under that part)” after “as cal-
 2 culated under subsection (c)”;

3 (2) by striking “that area, adjusted for such
 4 risk factors” and inserting “that area. In the case
 5 of payment for the benefits under parts A and B,
 6 such payment shall be adjusted for such risk factors
 7 as”; and

8 (3) by inserting before the last sentence the fol-
 9 lowing: “In the case of the payments for the benefits
 10 under part D, such payment shall initially be ad-
 11 justed for the risk factors of each enrollee as the
 12 Secretary determines to be feasible and appropriate
 13 to ensure actuarial equivalence. By 2006, the adjust-
 14 ments to payments for benefits under part D shall
 15 be for the same risk factors used to adjust payments
 16 for the benefits under parts A and B.”.

17 (e) CALCULATION OF ANNUAL MEDICARE+CHOICE
 18 CAPITATION RATES.—Section 1853(c) of such Act (42
 19 U.S.C. 1395w–23(c)) is amended—

20 (1) in paragraph (1), in the matter preceding
 21 subparagraph (A), by inserting “for benefits under
 22 parts A and B” after “capitation rate”; and

23 (2) by adding at the end the following new
 24 paragraph:

1 “(8) PAYMENT FOR PART D BENEFITS.—The
2 Secretary shall determine a capitation rate for part
3 D benefits (for individuals enrolled under such part)
4 as follows:

5 “(A) DRUGS DISPENSED IN 2003.—In the
6 case of prescription drugs dispensed in 2003,
7 the capitation rate shall be based on the pro-
8 jected national per capita costs for prescription
9 drug benefits under part D and associated
10 claims processing costs for beneficiaries enrolled
11 under part D and not enrolled with a
12 Medicare+Choice organization under this part.

13 “(B) DRUGS DISPENSED IN SUBSEQUENT
14 YEARS.—In the case of prescription drugs dis-
15 pensed in a subsequent year, the capitation rate
16 shall be equal to the capitation rate for the pre-
17 ceding year increased by the Secretary’s esti-
18 mate of the projected per capita rate of growth
19 in expenditures under this title for an individual
20 enrolled under part D for such subsequent
21 year.”.

22 (f) LIMITATION ON ENROLLEE LIABILITY.—Section
23 1854(e) of such Act (42 U.S.C. 1395w–24(e)) is amended
24 by adding at the end the following new paragraph:

1 “(5) SPECIAL RULE FOR PART D BENEFITS.—

2 With respect to outpatient prescription drug benefits
 3 under part D, a Medicare+Choice organization may
 4 not require that an enrollee pay a deductible or a co-
 5 insurance percentage that exceeds the deductible or
 6 coinsurance percentage applicable for such benefits
 7 for an eligible beneficiary under part D.”.

8 (g) REQUIREMENT FOR ADDITIONAL BENEFITS.—

9 Section 1854(f)(1) of such Act (42 U.S.C. 1395w-
 10 24(f)(1)) is amended by adding at the end the following
 11 new sentence: “Such determination shall be made sepa-
 12 rately for the benefits under parts A and B and for pre-
 13 scription drug benefits under part D.”.

14 (h) EFFECTIVE DATE.—The amendments made by
 15 this section shall apply to items and services provided
 16 under a Medicare+Choice plan on or after January 1,
 17 2003.

18 **SEC. 4. EXCLUSION OF PART D COSTS FROM DETERMINA-**
 19 **TION OF PART B MONTHLY PREMIUM.**

20 Section 1839(g) of the Social Security Act (42 U.S.C.
 21 1395r(g)) is amended—

22 (1) by striking “attributable to the application
 23 of section” and inserting “attributable to—

24 “(1) the application of section”;

1 (2) by striking the period and inserting “;
2 and”; and

3 (3) by adding at the end the following new
4 paragraph:

5 “(2) the program under part D providing pay-
6 ment for covered outpatient drugs (including costs
7 associated with making payments to employers and
8 other sponsors of employment-based health care cov-
9 erage under the Employer Incentive Program under
10 section 1860I).”.

11 **SEC. 5. REPORTING REQUIREMENTS FOR SECRETARY OF**
12 **THE TREASURY REGARDING INCOME-RE-**
13 **LATED PART D PREMIUM.**

14 (a) IN GENERAL.—Subsection (l) of section 6103 of
15 the Internal Revenue Code of 1986 (relating to disclosure
16 of returns and return information for purposes other than
17 tax administration) is amended by adding at the end the
18 following new paragraph:

19 “(18) DISCLOSURE OF RETURN INFORMATION
20 TO CARRY OUT INCOME-RELATED REDUCTION IN
21 MEDICARE PART D PREMIUM.—

22 “(A) IN GENERAL.—The Secretary may,
23 upon written request from the Secretary of
24 Health and Human Services, disclose to officers
25 and employees of the Health Care Financing

1 Administration return information with respect
2 to a taxpayer who is required to pay a monthly
3 premium under part D of the Social Security
4 Act. Such return information shall be limited
5 to—

6 “(i) taxpayer identity information
7 with respect to such taxpayer,

8 “(ii) the filing status of such tax-
9 payer,

10 “(iii) the adjusted gross income of
11 such taxpayer,

12 “(iv) the amounts excluded from such
13 taxpayer’s gross income under sections 135
14 and 911,

15 “(v) the interest received or accrued
16 during the taxable year which is exempt
17 from the tax imposed by chapter 1 to the
18 extent such information is available, and

19 “(vi) the amounts excluded from such
20 taxpayer’s gross income under sections 931
21 and 933 to the extent such information is
22 available.

23 “(B) RESTRICTION ON USE OF DISCLOSED
24 INFORMATION.—Return information disclosed
25 under subparagraph (A) may be used by offi-

1 cers and employees of the Health Care Financ-
 2 ing Administration only for the purposes of,
 3 and to the extent necessary in, establishing the
 4 appropriate monthly premium under part D of
 5 the Social Security Act.”.

6 (b) CONFORMING AMENDMENT.—Paragraphs (3)(A)
 7 and (4) of section 6103(p) of such Code are each amended
 8 by striking “or (17)” each place it appears and inserting
 9 “(17), or (18)”.

10 **SEC. 6. ADDITIONAL ASSISTANCE FOR LOW-INCOME BENE-**
 11 **FICIARIES.**

12 (a) INCLUSION IN MEDICARE COST-SHARING.—Sec-
 13 tion 1905(p)(3) of the Social Security Act (42 U.S.C.
 14 1396d(p)(3)) is amended—

15 (1) in subparagraph (A)—

16 (A) in clause (i), by striking “and” at the
 17 end;

18 (B) in clause (ii), by inserting “and” at
 19 the end; and

20 (C) by adding at the end the following new
 21 clause:

22 “(iii) premiums under section 1860D.”;

23 (2) in subparagraph (B), by striking “section
 24 1813” and inserting “sections 1813 and 1860E(b)”;
 25 and

1 (3) in subparagraph (C), by striking “section
2 1813 and section 1833(b)” and inserting “sections
3 1813, 1833(b), and 1860E(a)”.

4 (b) EXPANSION OF MEDICAL ASSISTANCE.—Section
5 1902(a)(10)(E) of the Social Security Act (42 U.S.C.
6 1396a(a)(10)(E)) is amended—

7 (1) in clause (iii)—

8 (A) by striking “section 1905(p)(3)(A)(ii)”
9 and inserting “clauses (ii) and (iii) of section
10 1905(p)(3)(A), for the coinsurance described in
11 section 1860E(b), and for the deductible de-
12 scribed in section 1860E(a)”;

13 (B) by striking “and” at the end;

14 (2) by redesignating clause (iv) as clause (vi);

15 and

16 (3) by inserting after clause (iii) the following
17 new clauses:

18 “(iv) for making medical assistance avail-
19 able for medicare cost-sharing described in sec-
20 tion 1905(p)(3)(A)(iii), for the coinsurance de-
21 scribed in section 1860E(b), and for the de-
22 ductible described in section 1860E(a) for indi-
23 viduals who would be qualified medicare bene-
24 ficiaries described in section 1905(p)(1) but for
25 the fact that their income exceeds 120 percent

1 but does not exceed 135 percent of such official
 2 poverty line for a family of the size involved;

3 “(v) for making medical assistance avail-
 4 able for medicare cost-sharing described in sec-
 5 tion 1905(p)(3)(A)(iii) on a linear sliding scale
 6 based on the income of such individuals for in-
 7 dividuals who would be qualified medicare bene-
 8 ficiaries described in section 1905(p)(1) but for
 9 the fact that their income exceeds 135 percent
 10 but does not exceed 150 percent of such official
 11 poverty line for a family of the size involved;
 12 and”.

13 (c) NONAPPLICABILITY OF PAYMENT DIFFERENTIAL
 14 REQUIREMENTS TO MEDICARE PART D COST-SHAR-
 15 ING.—Section 1902(n)(2) of the Social Security Act (42
 16 U.S.C. 1396a(n)(2)) is amended by adding at the end the
 17 following new sentence: “The preceding sentence shall not
 18 apply to coinsurance described in section 1860E(b) or
 19 deductibles described in section 1860E(a).”.

20 (d) 100 PERCENT FEDERAL MEDICAL ASSISTANCE
 21 PERCENTAGE.—The first sentence of section 1905(b) of
 22 the Social Security Act (42 U.S.C. 1396d(b)) is
 23 amended—

24 (1) by striking “and” before “(3)”; and

1 (2) by inserting before the period at the end the
 2 following: “, and (4) the Federal medical assistance
 3 percentage shall be 100 percent with respect to med-
 4 ical assistance provided under clauses (iv) and (v) of
 5 section 1902(a)(10)(E)”.

6 (e) TREATMENT OF TERRITORIES.—Section 1108(g)
 7 of such Act (42 U.S.C. 1308(g)) is amended by adding
 8 at the end the following new paragraph:

9 “(3) Notwithstanding the preceding provisions of this
 10 subsection, with respect to fiscal year 2003 and any fiscal
 11 year thereafter, the amount otherwise determined under
 12 this subsection (and subsection (f)) for the fiscal year for
 13 a Commonwealth or territory shall be increased by the
 14 ratio (as estimated by the Secretary) of—

15 “(A) the aggregate amount of payments made
 16 to the 50 States and the District of Columbia for
 17 the fiscal year under title XIX that are attributable
 18 to making medical assistance available for individ-
 19 uals described in clauses (i), (iii), (iv), and (v) of
 20 section 1902(a)(10)(E) for payment of medicare
 21 cost-sharing that consists of premiums under section
 22 1860D, coinsurance described in section 1860E(b),
 23 or deductibles described in section 1860E(a); to

1 “(B) the aggregate amount of total payments
2 made to such States and District for the fiscal year
3 under such title.”.

4 (f) CONFORMING AMENDMENTS.—Section 1933 of
5 the Social Security Act (42 U.S.C. 1396u–3) is
6 amended—

7 (1) in subsection (a), by striking “section
8 1902(a)(10)(E)(iv)” and inserting “section
9 1902(a)(10)(E)(vi)”;

10 (2) in subsection (c)(2)(A)—

11 (A) in clause (i), by striking “section
12 1902(a)(10)(E)(iv)(I)” and inserting “section
13 1902(a)(10)(E)(vi)(I)”;

14 (B) in clause (ii), by striking “section
15 1902(a)(10)(E)(iv)(II)” and inserting “section
16 1902(a)(10)(E)(vi)(II)”;

17 (3) in subsection (d), by striking “section
18 1902(a)(10)(E)(iv)” and inserting “section
19 1902(a)(10)(E)(vi)”;

20 (4) in subsection (e), by striking “section
21 1902(a)(10)(E)(iv)” and inserting “section
22 1902(a)(10)(E)(vi)”.

23 (g) EFFECTIVE DATE.—The amendments made by
24 this section shall apply for medical assistance provided
25 under section 1902(a)(10)(E) of the Social Security Act

1 (42 U.S.C. 1396a(a)(10)(E)) on and after January 1,
2 2003.

3 **SEC. 7. MEDIGAP REVISIONS.**

4 Section 1882 of the Social Security Act (42 U.S.C.
5 1395ss) is amended by adding at the end the following
6 new subsection:

7 “(v) MODERNIZED BENEFIT PACKAGES FOR MEDI-
8 CARE SUPPLEMENTAL POLICIES.—

9 “(1) PROMULGATION OF MODEL REGULA-
10 TION.—

11 “(A) NAIC MODEL REGULATION.—If,
12 within 9 months after the date of enactment of
13 the Medicare Outpatient Drug Act of 2000, the
14 National Association of Insurance Commis-
15 sioners (in this subsection referred to as the
16 ‘NAIC’) changes the 1991 NAIC Model Regula-
17 tion (described in subsection (p)) to revise the
18 benefit packages classified as ‘H’, ‘I’, and ‘J’
19 under the standards established by subsection
20 (p)(2) (including the benefit package classified
21 as ‘J’ with a high deductible feature, as de-
22 scribed in subsection (p)(11)) so that—

23 “(i) the coverage for outpatient pre-
24 scription drugs available under such ben-
25 efit packages is replaced with coverage for

1 outpatient prescription drugs that com-
2 pliments but does not duplicate the bene-
3 fits for outpatient prescription drugs that
4 beneficiaries are otherwise entitled to
5 under this title;

6 “(ii) the revised benefit packages pro-
7 vide a range of coverage options for out-
8 patient prescription drugs for beneficiaries,
9 but do not provide coverage for—

10 “(I) the deductible under section
11 1860E(a); or

12 “(II) more than 90 percent of
13 the coinsurance applicable to an indi-
14 vidual under section 1860E(b);

15 “(iii) uniform language and defini-
16 tions are used with respect to such revised
17 benefits;

18 “(iv) uniform format is used in the
19 policy with respect to such revised benefits;
20 and

21 “(v) such revised standards meet any
22 additional requirements imposed by the
23 Medicare Outpatient Drug Act of 2000;

24 subsection (g)(2)(A) shall be applied in each
25 State, effective for policies issued to policy hold-

ers on and after January 1, 2003, as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to the 1991 NAIC Model Regulation as changed under this subparagraph (such changed regulation referred to in this section as the ‘2003 NAIC Model Regulation’).

“(B) REGULATION BY THE SECRETARY.—
If the NAIC does not make the changes in the 1991 NAIC Model Regulation within the 9-month period specified in subparagraph (A), the Secretary shall promulgate, not later than 9 months after the end of such period, a regulation and subsection (g)(2)(A) shall be applied in each State, effective for policies issued to policy holders on and after January 1, 2003, as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to the 1991 NAIC Model Regulation as changed by the Secretary under this subparagraph (such changed regulation referred to in this section as the ‘2003 Federal Regulation’).

“(C) CONSULTATION WITH WORKING GROUP.—In promulgating standards under this paragraph, the NAIC or Secretary shall consult

1 with a working group similar to the working
2 group described in subsection (p)(1)(D).

3 “(D) MODIFICATION OF STANDARDS IF
4 MEDICARE BENEFITS CHANGE.—If benefits (in-
5 cluding deductibles and coinsurance) under part
6 D of this title are changed and the Secretary
7 determines, in consultation with the NAIC, that
8 changes in the 2003 NAIC Model Regulation or
9 2003 Federal Regulation are needed to reflect
10 such changes, the preceding provisions of this
11 paragraph shall apply to the modification of
12 standards previously established in the same
13 manner as they applied to the original estab-
14 lishment of such standards.

15 “(2) CONSTRUCTION OF BENEFITS IN OTHER
16 MEDICARE SUPPLEMENTAL POLICIES.—Nothing in
17 the benefit packages classified as ‘A’ through ‘G’
18 under the standards established by subsection (p)(2)
19 (including the benefit package classified as ‘F’ with
20 a high deductible feature, as described in subsection
21 (p)(11)) shall be construed as providing coverage for
22 benefits for which payment may be made under part
23 D.

24 “(3) APPLICATION OF PROVISIONS AND CON-
25 FORMING REFERENCES.—

“(A) APPLICATION OF PROVISIONS.—The provisions of paragraphs (4) through (10) of subsection (p) shall apply under this section, except that—

“(i) any reference to the model regulation applicable under that subsection shall be deemed to be a reference to the applicable 2003 NAIC Model Regulation or 2003 Federal Regulation; and

“(ii) any reference to a date under such paragraphs of subsection (p) shall be deemed to be a reference to the appropriate date under this subsection.

“(B) OTHER REFERENCES.—Any reference to a provision of subsection (p) or a date applicable under such subsection shall also be considered to be a reference to the appropriate provision or date under this subsection.”.

SEC. 8. HHS STUDIES AND REPORT TO CONGRESS.

(a) STUDIES.—The Secretary of Health and Human Services shall conduct a study to determine the feasibility and advisability of—

(1) establishing a uniform format for pharmacy benefit cards provided to beneficiaries by eligible entities under the outpatient prescription drug benefit

1 program under part D of title XVIII of the Social
2 Security Act (as added by section 2); and

3 (2) developing systems to electronically transfer
4 prescriptions under such program from the pre-
5 scriber to the pharmacist.

6 (b) REPORT.—Not later than 2 years after the date
7 of enactment of this Act, the Secretary of Health and
8 Human Services shall submit to Congress a report on the
9 results of the studies conducted under subsection (a), to-
10 gether with any recommendations for legislation that the
11 Secretary determines to be appropriate as a result of such
12 studies.

13 **SEC. 9. APPROPRIATIONS.**

14 In addition to amounts otherwise appropriated to the
15 Secretary of Health and Human Services, there are au-
16 thorized to be appropriated to the Secretary for fiscal year
17 2001 and each subsequent fiscal year such sums as may
18 be necessary to administer the outpatient prescription
19 drug benefit program under part D of title XVIII of the
20 Social Security Act (as added by section 2).

